ProCare Physical Therapy
19033 E. Plaza Drive
Parker, CO 80134
(303) 805-4497

Confidential Massage Patient Information

Name_____________________________ Home Phone______________________ Work #_________________

Address___________________________ City/Zip Code_____________________ Cell #__________________

Age_______ Date of Birth___________ Marital Status_________ Spouse's Name_______________________

Occupation____________ Employer Name & Address____

Social Security Number:_____________ Emergency Contact Name and Phone #:________________________

How did you hear about us?
Referral_________ By Whom?________________ Phone Book_______ Drive By_______ Other___________

Have you ever experienced a professional massage?_____________ If so, when?_________________________

General Medical Information:
Did you have a motor vehicle accident, a work comp injury, or chronic pain due to other circumstances? Please explain: ____

____

Describe any health condition(s) treated by a physician in the last year:___________________________________

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Please circle any of the following conditions that you currently have **OR** have had:

			(circle appropriate one)
Atherosclerosis	Asthma	Blood Clots/Thrombosis	Blood Pressure—High or Low
Blurred Vision	Bowel/Bladder	Broken Bones (last 3 yrs.)	Cancer
Chronic Pain	Currently Pregnant	Diabetes	Dizziness/Nausea
Fibromyalgia	Frequent Headaches	Heart Problems	Infectious Disease
Inflammation	Kidney Infection	Lupus	Multiple Sclerosis
Osteoporosis	Peritonitis	Repetitive Use Injury	Respiratory Problems
Rheumatiod Arthritis	Skin Infection	Skin Sensitivity	Stroke
Surgery (last 6 mos.)	TMJ	Traumatic Head Injury	Viral Infection

Explanations:____

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Do you generally have tension or soreness in a specific area? If so where? ______________________________
____

Are you very sensitive to touch or pressure in those, or any other areas? ________________________________
____

Do you have numbness or stabbing pains anywhere? If so, where? ____________________________________
____

Do you have any other medical conditions that *ProCare* Physical Therapy should be aware of? _____________

____

Please **read** and **understand** the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A written referral from your primary care physician may be required prior to service being provided.

I understand that the massage (s) I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during any session, I will immediately inform the practitioner so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, specialist for any mental or physical ailment that I am aware of. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of any session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of any session, and I will be liable for payment of the full scheduled appointment.

Patient Signature____ Date_________________________

Practitioner Signature____ Date_________________________

Consent to treatment of a minor: By my signature below, I hereby authorize ____________________________
to administer massage therapy to my child or dependent as they deem necessary.

Signature of Parent or Guardian________________________________ Date_________________________